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IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,

Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,

Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR CALIFORNIA CONSUMER HEALTH CARE COUNCIL; CALIFORNIA COALITION FOR ETHICAL MENTAL HEALTH CARE; CONGRESS OF CALIFORNIA SENIORS; AND HEALTH ADMINISTRATION RESPONSIBILITY PROJECT AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

SHARON J. ARKIN
ROBINSON, CALCAGNIE & ROBINSON
Attorneys for Amici Curiae
620 Newport Center Drive
Seventh Floor
Newport Beach, CA 92660
(949) 720-1288

170650

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

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INTEREST OF THE AMICI CURIAE

This brief is respectfully submitted on behalf of amici curiae California Consumer Health Care Council, California Coalition for Ethical Mental Health Care, Congress of California Seniors, and Health Administration Responsibility Project.[1] The interests of the amici curiae are as follows:

California Consumer Health Care Council (CCHCC), is a California non-profit, grassroots, volunteer-governed and operated, public benefit corporation. CCHCC acts as an advocate, in all available forums, to protect health care consumers from dangerous, deceptive, dishonest, unlawful or unfair practices. Ensuring that existing laws designed to protect consumers from improper acts and practices by managed care organizations and other health insurers ("MCOs") are fully enforced is central to CCHCC's purpose. CCHCC has among its constituents all California consumers affected by limitations on available redress and is dedicated to preserving and obtaining, through the courts, the power to hold MCOs accountable for improper conduct. The issues addressed in this case potentially impact health care regulation in California and the existing statutory provisions regulating managed care plans in this state (California Civil Code 3428) and are of immediate and substantial concern to this organization and its constituency.

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1. Letters from Petitioner and Respondents granting consent to the filing of this brief have been lodged with this Court. Pursuant to Rule 37.6, Amici disclose that no counsel for a party authored any part of this brief, nor did any person or entity other than Amici Curiae, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

California Coalition for Ethical Mental Health Care (CCEMHC) is a non-profit group composed of mental health patients and clients, family members and advocates, mental health professionals from all the disciplines licensed in California, and other interested members. The organization's mission is to advance access to quality, affordable mental health care through the coordinated efforts of mental health consumers and professionals. CCEMHC works to promote continuity of care, guarantee patients' right to make informed choices when selecting therapists and modalities of treatment, and eliminate the use of pernicious financial incentives which limit access to needed care. CCEMHC has an abiding interest in the issue presented in this case because it believes that health plans should be held accountable through strong regulation of the insurance industry and the unfettered right to seek redress through the legal system.

Congress of California Seniors (CCS), is a statewide non-profit education and advocacy organization dedicated to improving the life of seniors and their families. CCS devotes its efforts to legislative and consumer affairs that deal primarily with issues concerning older adults. CCS conducts research, analyzes issues and provides voter and consumer education to its members. Through an effective legislative committee, CCS initiates and monitors legislation, testifies at hearings and takes appropriate grass-roots action on pending and proposed legislation. When necessary, CCS initiates or joins in lawsuits to protect consumers. CCS supported the California HMO legislation (Civil Code section 3428) which contains an independent review requirement similar to that at issue in this case and which may be impacted by the decision here and is therefore vitally interested in the issues presented.

Health Administration Responsibility Project (HARP) is a non-profit organization that serves as an educational and informational resource for patients, doctors, and attorneys regarding managed care organizations, and seeks to enhance the quality of medical care benefits provided in the managed care setting. Because this case implicates a statutorily-required independent review process similar to that established under California law (Civil Code section 3428), HARP has an immediate interest in assuring that such protections remain viable and enforceable.

SUMMARY OF ARGUMENT

This Court's analysis of the interplay between state law remedies and ERISA's remedies provision in the second half of its decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) has been construed as standing for the following proposition: ERISA preempts *any* state law, even one regulating insurance, that provides a remedies scheme different than that afforded under ERISA. *New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 494 (9th Cir. 1988); *Commercial Life Ins. Co. v. Superior Court (Juliano)*, 47 Cal. 3d 473, 480 (1988).

That fundamental premise should be re-examined. In fact, both the statutory interplay between ERISA's remedy provision and its preemption provision and the McCarran-Ferguson Act itself, mandate that a state law that regulates insurance and provides a remedy different than that provided under ERISA, is saved from ERISA preemption.[2]

2. For purposes of this brief, it will be assumed that health maintenance organizations, managed care entities, and the like, are, (Cont'd)

There are two reasons for this: First, ERISA's preemption provision, section 514(b)(2)(A), codified at 29 U.S.C. § 1144(b)(2)(A), explicitly provides that "*nothing in this subchapter* shall be construed to exempt or relieve any person from *any* law of any State which regulates insurance, banking or securities." (Emphasis added.) The subchapter referenced in that subdivision, *includes ERISA's remedies provisions*, i.e., ERISA section 502, 29 U.S.C. § 1132. Congress said it very plainly: *Nothing* in the subchapter — including the remedies provision — can be construed to exempt insurers from state law regulation. That must, therefore, necessarily include state laws regulating the remedies imposed on insurers.

Nor does this do any harm to Congress's intent to provide administrative protection to ERISA plans. As this Court acknowledged in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), there is a distinction — and properly so — between ERISA

(Cont'd)

in fact, "in the business of insurance." *See Sarchett v. Blue Shield of Ca., Inc.*, 43 Cal. 3d 1, 3 n.1 (1987); In *Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039, 1045-1046 (9th Cir. 1998); *McEvoy v. Group Health Cooperative of Eau Claire*, 213 Wis. 2d 507, 570 N.W.2d 397 (1997); *Kentucky Assoc. of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 364 (6th Cir. 2000); *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994); *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101, 1107-1108 (1st Cir. 1989); California Managed Health Care Insurance Accountability Act of 1999, Statutes, Chapter 536, section 2; Joanne B. Stern, *Bad Faith Suits Against HMOs: Finally, a Breakthrough*, 1998, Whittier Law Review, Vol. 20, No. 2; Stern, *Bad Faith Suits: Are They Applicable to Health Maintenance Organizations?*, Summer 1983, West Virginia Law Review, Vol. 85, No. 5, p. 911. And any reference to "insurance" in this brief is intended to include HMOs and other managed care entities.

plans themselves and the insurance protection they buy. Allowing state laws to impose different remedies against *insurance companies* when *insurance companies* violate state insurance law does nothing to thwart Congress's intent to protect the administrative regulation of the plan itself.

Nor is there any basis for a claim by insurers or managed care plans that they would be harmed by varying state regulation where they issue their coverage to ERISA-preempted employer plans. This is because — very simply — they are subject to varying state regulation *anyway*. Indeed, every managed care company inevitably issues coverage to both non-ERISA plans (e.g., school districts, city, county, and state governments, churches) as well as ERISA plans. They are clearly subject to state regulation — and state law remedies — where they issue coverage to non-ERISA plans. They must necessarily, therefore, be perfectly capable of managing their business under state law auspices. Nothing changes simply because some of their coverage is issued to ERISA plans as well.

Second, the refusal to apply state law remedies that regulate insurance simply because the particular coverage is issued to an ERISA entity violates the express mandate of the McCarran-Ferguson Act which forbids any such federal regulation of the insurance industry. 15 U.S.C. § 1011, *et seq*. That statutory scheme forbids "inadvertent" preemption of state insurance laws by other federal legislation in the absence of congressional specification that the federal law is intended to regulate insurance. Since there is no such expression in ERISA — indeed, ERISA indicates just the opposite since the savings clause, ERISA section 514(b), 29 U.S.C. § 1144(b), expressly provides otherwise — the McCarran-Ferguson Act "trumps" ERISA and *no* state

law falling within the ambit of McCarran-Ferguson, even one that provides remedies different from ERISA, can be preempted by ERISA.

Because both the statutory structure of ERISA itself and the impact of the McCarran-Ferguson Act preclude preemption of state laws regulating insurance — even where that law provides for remedies not available under ERISA — the second half of the *Pilot Life* decision, to the extent it holds that any state remedy, even one regulating insurance, is preempted by ERISA, must be reversed.

ARGUMENT

I.

ERISA'S STATUTORY STRUCTURE PRECLUDES PREEMPTION OF STATE LAW REMEDIES THAT REGULATE INSURANCE

ERISA's civil enforcement provision, section 502, 29 U.S.C. § 1132, is subject to ERISA's preemption provision, section 514, 29 U.S.C. § 1144. Nothing in the express provisions of the civil enforcement section states that the terms and provisions of that section do, or are intended to, establish or provide a preemption power distinct from the preemption provision itself. Indeed, section 1132 is utterly silent as to the preemptive effect of its civil enforcement scheme.

The only preemption language in ERISA, in fact, is contained in section 1144. The actual structure of ERISA's provisions is unambiguous: None of the definitional, substantive, procedural or other provisions contain any preemption provisions at all. Thus, it was obviously the

drafters' intent that section 1144 establish and set forth the preemptive power of the act itself as a whole, as well as the preemptive effect of each individual provision of the act.

Thus, the determination of whether the civil enforcement provision of the act (section 1132) preempts a state law remedy or enforcement scheme is controlled by the preemption analysis applicable under section 1144.

Under section 1144(a), the provisions of the act, including the civil enforcement section, "supersede any and all State laws insofar as they . . . relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." This is commonly referred to as the "preemption provision."

Section 1144(b) is entitled "Construction and application" and delineates how section 1144 is to be applied. Section 1144(b)(2)(A) is commonly referred to as the "savings clause" and provides:

> Except as provided in subparagraph (B), *nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.*

(Emphasis added.)

The conclusion that the civil enforcement scheme established under 1132 is subject to the preemption rules set forth in section 1144 is mandated by the fact that the savings clause expressly states that it applies to *all* the provisions *of the subchapter*. Sections 1132 and 1144 are both contained *in the same subchapter*: Title 29, Chapter 18, Subchapter I.

Thus, Congress expressly provided that ERISA's civil enforcement provisions are not to exempt or relieve any person from any law which regulates insurance — even where that law provides an alternative remedy scheme.

Notably, subjecting *insurers* to state law regulatory remedies for improper claims processing under policies issued to ERISA plans does not imperil Congress's intent to protect ERISA *plans* from liability beyond the scope of section 1132. As this Court expressed in *Travelers*, Congress's intent in establishing its exclusive civil enforcement scheme was to protect *plans* from differing standards among the states which would subject the *plan* to varying administrative requirements. *Travelers*, *supra*, 514 U.S. at 656-657. Congress also wanted to protect the financial integrity of the plan's assets by assuring that the plan's funds would not be depleted by awards of extra-contractual damages under varying state laws. *Pohl v. National Benefits Consultants*, 956 F.2d 126, 128 (7th Cir. 1992).

And if the state laws regulating claims processing applied to the *plan*, that analysis would be valid. But where the state law applies to the practices and procedures employed by *insurance companies or managed care entities*, even when they are processing claims under policies issued to ERISA plan beneficiaries, those rationales break down:

First, the insurer, with respect to claims under its non-ERISA policies (including policies issued to government plans and church plans which are exempted from ERISA preemption, *see* 29 U.S.C. § 1003(b)), is already subject to varying state law administrative requirements and must conform its claims processing to different laws among the states in which it conducts business. Requiring the insurer

to do the same with respect to the processing of claims under ERISA policies adds nothing to the burden the insurer already bears.

Second, state laws imposing damages beyond those permitted under ERISA against the *insurance company* does nothing to deplete the assets of the *ERISA plan*. Since state laws regulating insurance can be applied only to an insurer engaged in the business of insurance, and since insurers pay claims submitted under policies issued by them out of their own general accounts and do not pay claims out of the *plan's* ERISA account, any damages awarded can necessarily affect only the *insurer's* general account. As such, the *plan's* account is not impacted and cannot be depleted or affected by the state law in abrogation of section 1132.

And, finally, this Court has already rejected the argument that ERISA "relates to" a law simply because the law may increase the cost to the ERISA plan of purchasing products. *Travelers*, *supra*, 514 U.S. at 659-660. Thus, the fact that an insurer who has higher costs from imposition of remedies under state law may have to increase premium costs does not warrant ERISA preemption.

Indeed, this Court's decision in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) highlights the distinction between regulation of plans and regulation of insurers. In *FMC*, this Court strongly distinguished between regulatory provisions applicable to a self-insured plan and a plan which fulfilled its fiduciary obligation to provide benefits through the purchase of insurance:

> *An insurance company that insures a plan remains an insurer for purposes of state laws* "purporting

> to regulate insurance" after application of the deemer clause. *The insurance company is therefore not relieved from state insurance regulation.* [¶] Our decision, we acknowledged, "results in a distinction between insured and uninsured plans, leaving the former *open to indirect regulation while the later are not.*" . . . "*By doing so, we merely give life to a distinction created by Congress in the 'deemer clause,'* a distinction Congress is aware of and one it has chosen not to alter." [¶] By recognizing a distinction between insurers of plans and the contracts of those insurers, *which are subject to direct state regulation*, and self-insured employee benefit plans governed by ERISA, which are not, we observe Congress's presumed desire to reserve to the States the regulation of the "business of insurance."

Id. at 61-63; emphasis added.

This Court also went on to note:

> As we have pointed out . . . , the savings clause retains the *independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans.* [¶] . . . Our interpretation of the deemer clause makes clear that *if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts*; if the plan is uninsured, the State may not regulate it. As a result, *employers will not face "conflicting or inconsistent State and local regulation of employee benefit plans.*"

Id. at 64; emphasis added.

As acknowledged by this Court in *FMC*, there is a distinction between regulation of a plan and regulation of an insurance company that issues coverage to a plan. That distinction does not, and should not, fall apart simply because the state law regulation of the insurance company imposes remedies that differ from ERISA's — because, again, it is the insurer being regulated, not the plan.

Since ERISA's own preemption structure mandates that a state law regulating insurance be saved from preemption, even with respect to the part of the subchapter containing the remedies provision, statutory construction principles require that the remedies provision be subjugated to the preemption provision. As such, ERISA's remedies scheme must give way to any state insurance regulation providing remedies different from those in ERISA.

II.

APPLYING ERISA'S REMEDY LIMITATIONS TO INSURERS VIOLATES THE MCCARRAN-FERGUSON ACT

That Congress intended ERISA's remedy structure to be subjugated to state insurance law regulation is wholly logical and consistent with the fact that to do otherwise would violate the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq*. Indeed, to construe section 1132 and section 1144 any other way would conflict with — and be overridden by — McCarran-Ferguson. This is because McCarran-Ferguson expressly provides that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance. . . . unless such Act *specifically relates* to the business of insurance." 15 U.S.C. § 1012(b); emphasis added.

As expressed by this Court in *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453 (1969), the purpose of the McCarran-Ferguson Act was to assure that activities of insurance companies in dealing with their policyholders would remain *subject to state regulation*. And, as noted by the Ninth Circuit in *Merchants Home Delivery Service, Inc. v. Frank B. Hall & Co., Inc.*, 50 F.3d 1486 (9th Cir. 1995), *cert. denied*, 516 U.S. 964, 116 S. Ct. 418 (1995), the McCarran-Ferguson Act was specifically designed to prevent "inadvertent" preemption of state insurance laws by federal statutes of general application. Congress thus established its "inverse preemption" approach — meaning that a federal law that would otherwise preempt the state insurance law is itself preempted by McCarran-Ferguson, thus leaving the state law intact and enforceable, despite the otherwise expansive preemptive effect of the federal law.

The McCarran-Ferguson Act thus precludes *any* federal legislation from preempting state laws regulating the business of insurance *unless* the federal legislation is, itself, directly related to the business of insurance. *Merchants Home Delivery, supra.*

Thus, a federal statute cannot be enforced so long as the four following prongs are met:

(1) The federal statute does not "specifically relate" to the business of insurance;

(2) The acts challenged under the federal statute constitute the business of insurance;

(3) The state has enacted laws regulating the challenged acts; and,

(4) The state law would be superseded, impaired or invalidated by application of the federal statute. (*Id.*)

Assuming the state law at issue is one similar to that here, i.e., regulating the determination of whether a medical treatment is covered as medically necessary under the coverage provided through imposition of an independent review process, the question, then, is whether applying 29 U.S.C. § 1132 (ERISA's civil enforcement section) would violate the McCarran-Ferguson Act's prohibitions and would thus be unenforceable. Addressing the McCarran-Ferguson Act's elements seriatim:

A. Does ERISA specifically relate to the business of insurance?

As noted by this Court in *Barnett Bank of Marion County, N.A. v. Nelson*, 517 U.S. 25, 116 S. Ct. 1103 (1996), using the bankruptcy laws as an example, many federal statutes with potentially preemptive effect on state insurance laws use general language that does not appear to specifically relate to insurance. Where those statutes conflict with state law enacted for the purpose of regulating insurance, the McCarran-Ferguson Act's "antipreemption rule" will apply to prohibit federal preemption of those state laws and the state laws apply.

Obviously, ERISA does not relate, either generally or specifically, to the business of insurance. It relates to the business of pension plans and employee benefits. While employee benefits may be provided through the purchase of insurance, and ERISA would thus arguably have a potentially preemptive effect on state insurance laws, the effect would be collateral at best, much like bankruptcy laws might affect

the business of insurance, and could not rationally be construed as a law *specifically related* to the business of insurance.

In fact, the Ninth Circuit specifically held that ERISA fell within the preemption provisions of the McCarran-Ferguson Act, thus necessarily determining that it was not a law specifically related to the business of insurance. *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831, 99 S. Ct. 108 (1978).

B. Do the acts challenged under the federal law relate to the business of insurance?

The question here is whether the determination of whether a particular procedure is medically necessary, and therefore covered under the insurance policy, "relates to the business of insurance." As noted by this Court in one of its cases interpreting the "business of insurance" component of the McCarran-Ferguson Act, a state statute aimed at *protecting or regulating* the relationship between the insurance company and policyholder, *directly or indirectly* are laws regulating the business of insurance. *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 89 S. Ct. 564 (1969).

And where the state itself determines that an activity constitutes the "business of insurance," the federal courts will give great weight to that determination. *Royal Drug Co., Inc. v. Group Life & Health Ins. Co.*, 556 F.2d 1375 (5th Cir. 1977), *affirmed*, 435 U.S. 903, 98 S. Ct. 2017 (1978). Thus, if the legislation itself provides that the intent of the statute is to regulate the business of insurance, that will require the federal courts to give great weight to that

conclusion. Under the California law providing for independent review of a health plan's medical necessity determinations, the Legislature expressly found that the managed care entities were, in fact, engaged in the business of insurance. California Managed Health Care Insurance Accountability Act of 1999, Statutes, Chapter 536, section 2.

Furthermore, in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743-744 (1985), this Court essentially provided that the core issues in the "business of insurance" determination included the type of policy, its reliability, its interpretation, and its enforcement. Obviously, a state regulatory statute that expressly deals with the *enforcement* of the insured's policy rights falls squarely within the McCarran-Ferguson Act's provisions.

Other cases also support that conclusion. The court in *Lowe v. Aarco-Am., Inc.*, 536 F.2d 1160 (7th Cir. 1976), in concluding that the business of insurance includes setting insurance rates and terms for financing premiums as well as disclosure of such terms, stated that the "business of insurance" includes more than "just" questions of validity and enforceability of insurance policies. Obviously, a statute regulating the appropriate handling of coverage determinations, and requiring that coverage promised under the plan be provided, specifically relates to the *enforceability* of policies.

Also, in *Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau*, 701 F.2d 1276 (9th Cir. 1983), *cert. denied*, 464 U.S. 822, 104 S. Ct. 88 (1983), the court held that Oregon's regulations banning unfair or deceptive acts or practices constituted regulation of the business of insurance under the Act. And in *Freier v. New York Life Ins.*

Co., 679 F.2d 780 (9th Cir. 1982), the court held that the relationship between an insurer making payments to a disabled employee under a group term policy issued to the employer was an activity that fell within the definition of business of insurance.

And this law falls within the protection of the McCarran-Ferguson Act even under the standard mantra that, in order to be considered part of the business of insurance, the targeted activity must have the effect of transferring or spreading policyholder's risk, the practice must be an integral party of a policy relationship and the practice must be limited to entities within the insurance industry. *Ticor Title Ins. Co. v. F.T.C.*, 998 F.2d 1129 (3d Cir. 1993), *cert. denied*, 510 U.S. 1190, 114 S. Ct. 1292 (1994).

First, of course, if an insurer refuses to cover a treatment under the policy on the grounds that it is not medically necessary and therefore not covered when, in fact, it is, the insurer is directly impacting the spreading of policyholder risk. Because the insurer is not paying on covered claims, it is leaving the policyholder bearing a risk that the insurer had accepted a premium to assume.

And, obviously, the payment — or nonpayment — of claims is the very thing contracted for by the insured and is thus integral to the policy relationship.

Lastly, of course, only insurers pay claims under insurance policies and since payment of the claims represent the ultimate outcome of promising indemnification for contingent risks, it is relevant only to the insurance industry.

Thus, legislation regulating whether a claim must be paid falls within the parameters of the business of insurance.

C. Has the state enacted laws regulating the challenged acts?

That is the starting premise, both with the Illinois law under consideration and the similar California law that may be impacted by the Court's decision in this case.

D. Would the state law be superseded, impaired or invalidated by application of the federal statute.

This prong, too, is well met. Obviously, if ERISA's civil enforcement scheme were applied to limit the damages recoverable under the state law provisions regarding the coverage or claims to be paid under the health care policy, it would do all three: supersede, impair and invalidate the state law.

Thus, the straightforward application of the McCarran-Ferguson Act precludes ERISA's preemption of a state law regulating claims determinations. That being the case, ERISA preemption of the state law regulating insurance on the basis that the state law's remedies provisions conflict with ERISA's remedies provisions is forbidden under the McCarran-Ferguson Act.

CONCLUSION

Because ERISA's statutory structure expressly provides that all state laws regulating insurance supercede even ERISA's own remedies provisions, and because any attempt to preempt state insurance laws would violate the McCarran-Ferguson Act, any conclusion to the contrary violates both ERISA and McCarran-Ferguson. That being the case, this Court should make manifestly clear that the mere fact that a state law providing a remedies scheme different from that set forth in ERISA is not preempted by ERISA where that state law is regulating the insurer rather than the plan.

Respectfully submitted,

SHARON J. ARKIN
ROBINSON, CALCAGNIE & ROBINSON
Attorneys for Amici Curiae
620 Newport Center Drive
Seventh Floor
Newport Beach, CA 92660
(949) 720-1288